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ABSTRACT

Articles included in this document serve as a means to educate teachers, school psychologists, and parents about attention problems in children. Attention problems, including Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder, are among the most common and most controversial disorders in children. Children with attention problems may have difficulty completing schoolwork, seem to tune out directions, and may seem to react without thinking. School psychologists can help identify children needing evaluation, assist children with developing strategies to manage their own behavior, and work with school personnel and parents to help create environments where these children can learn more. These articles provide an overview of attention problems, give examples of intervention for teachers and parents, include a parent's perspective and book reviews, and list resources for additional information. The NASP Position Statement on students with attention problems is included. (Contains 94 references.) (JDM)

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Attention Problems. Communique Special Edition, Spring 2000.

Andrea Canter and Victoria Stanhope, Eds.

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Communiqué

National Association of School Psychologists — Spring 2000 Special Edition

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SPECIAL EDITION: ATTENTION PROBLEMS

Attention problems, including ADD and ADHD, are among the most common as well as most controversial childhood difficulties. Children with attention problems often have difficulty completing school work, seem to "tune out" directions, may react "without thinking," and may have difficulty in social situations. Working with schools, families and community health care providers, school psychologists can help identify children needing evaluation, help children develop strategies to manage their own behavior, and work with parents and school personnel to help create environments where these children can learn more successfully. The articles compiled in this second special issue provide an overview of attention problems, examples of interventions for parents and teachers, and resources for more information. ♦

This issue edited by Andrea Canter, Ph.D., NCSP (Editor, Communiqué) & Victoria Stanhope (Director, Special Projects)

Are You Listening? — A Parent's Perspective on Attention Problems

by Leslie Hale, NCSP

Are you listening?" "What did I say?" I should have known early on that the hundreds of times I asked these questions were advance warnings of things to come. Other signs, like our son Joel insisting on knowing exactly what was going to happen at all times and his frequently saying "I'm bored!" while he sat in the middle of a room full of toys, should have told us something was amiss. But being the good, conscientious parents that we were, we assumed we just needed to speak to him more clearly; we needed to make him watch our faces while we were speaking to him; and finally, he needed to be rewarded when he listened and punished when he didn't. We thought that when our son said he was bored, he was just being unappreciative of what he had. When he insisted on knowing what would happen each minute of the day, he had just been overly protected by his mother (his dad's point of view, of course) and needed to be more independent.

What's Going On?

Warning signs: When Joel started school, we actually looked forward to the first parent conference with anticipation. We had received no calls from the teacher telling us about problems. Our son had told us about fun times and good friends, and he seemed to be learning letters, sounds, colors and all those good "school" things. We heard statements from his teacher that would be repeated every year from that point through this year's seventh grade parent conference: "Joel is a good student, but he really needs to lighten up." "Joel is just too serious about school. He needs to stop worrying so much." My husband and I looked at each other in amazement. We didn't feel that Joel got his "too serious" attitude from us. We

Continued on page 2

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■ Parent's Perspective... *from page 1*

were remembering the many times we had told him to not take things so seriously at home. In the next two years of his schooling, we got a few phone calls from teachers telling us that he had put his head down and cried at school because he was concerned with his performance on a task. When he was questioned and the work was reviewed, it always turned out that his concern had been unfounded and he had just not understood the directions. The other complaint we heard from Joel was that he never had time to complete his work. He said he had to ask a lot of questions, and then it was too late to finish.

At the same time that we became aware of the few problems at school, problems at home had mushroomed. Joel was often depressed about the amount of school work, his feeling of unacceptable work on his part, his feeling that no one liked him, and his feeling that his teachers didn't like or understand him. He often described feelings of being "all quivery inside" and of wanting to know "what's wrong with me?" At one time during the third grade, Joel actually said he did not want to "be around" any more. Along with our son's depression came frustrations on our part at not being able to allay Joel's fears, depression and concerns. Bouts of our son's depression were becoming compounded with sudden rages at home, occurring at the slightest (at least from parental points of view) provocation. We began tiptoeing around our child, amending all of our family's activities and communication patterns so that he wouldn't become so upset that we would not be able to handle his behavior or do anything together in public as a family.

When parents first start experiencing problems with their children and their relationship to school, they experience feelings that originate from their own school experiences as students. If their school experiences and their relationships with most teachers were positive, they will probably feel more comfortable communicating with the school personnel than will an individual whose experiences were negative. Because of my history as a professional (school psychologist) in the school district and my early positive experiences as a student, I did not hesitate to discuss my concerns with my son's teacher, counselor and principal. Our problems arose when they described a boy in their classrooms whom I did not recognize as the boy who returned from school into our home. The teacher described Joel as a serious, hard worker who did not always pay attention and who asked for help too often. His teacher did not see the depressed, angry child that I saw, but a quiet, serious child who didn't really like to have fun. The more frustrated and angry Joel became at home, the more work he didn't complete and the more puzzled the school became by my descriptions of the behavior that occurred at home. When I told them that he had bitten me and broken toys and a tape recorder, they were shocked.

The breakthrough came about at a conference with the teacher, counselor and school psychologist. The psychologist convinced the school staff to really listen to my concerns and my son's fears and frustrations. The information was recorded and the group brainstormed ways we could alleviate the stress in the classroom while arranging for a multi-disciplinary assessment for Joel. I contacted the pediatrician and the private family psychologist and the "helping Joel team" was born.

Diagnosis and intervention: At last, the insight of a teacher and the caring frequent dialogue with another school psychologist led us to look at a possible diagnosis of Attention Deficit Disorder to account for some of Joel's problems. Consultation with a physician, another psychologist who worked with ADD children and families, and a lot of reading led us to conclude that we had a place to start working on our family's quandary. We began the task of becoming more educated about the different behaviors that occur in many children with attention problems. While some children have trouble attending, others have trouble starting a task and/or switching their attention from one task to another (Zentall, 1992). When they say they are "bored" they may be verbalizing their need for additional stimulation or novelty (McNeil, 1993; Satterfield et al, 1990). These same children show behaviors that might be considered obsessive, insisting on near perfection in their work and even fun activities, while becoming depressed when that perfection is unattainable. They sometimes have peer problems because they expect perfection in their social relationships and/or they have problems meeting new people and only have a few that they know very well. Some children perform well in school's structure, but fall apart at home after surviving the stress of the day.

What our reading and interviews indicated was that there is no one set of characteristics that children with attention problems exhibit. Whether our son was identified as a child with "Attention Deficit Disorder" (with or without hyperactivity), a central auditory processing problem, a learning disability or just inattention, he still was experiencing high stress at school, feeling depressed, experiencing problems with social relationships and wreaking havoc on our home life!

We had Joel assessed by the school psychologist to ascertain his strengths and weaknesses on school tasks. With the psychologist's and speech pathologist's help, he was also diagnosed with a central auditory processing problem. We established a relationship with a private family and children's psychologist and began family counseling. We visited with our pediatrician, and with his help were referred to a child psychiatrist. Together they prescribed a regimen of Ritalin and Imipramine for Joel. All of these puzzle pieces were shared with Joel's teacher and she stayed in frequent contact with us (sometimes daily!), helping us to implement a multi-faceted plan to get our son to "lighten up," have more success in school and with friends, and to make ourselves a family again.

We survived that year and made progress that astounded us all. The move to middle school was very frightening, but with the help of the learning disabilities teacher, the school counselor and school psychologist, appropriate teachers were selected and the year was a great success all around. We are now in the midst of reassessing Joel's unique needs as an adolescent and looking at options in medication strategies. School has not been quite so successful; stress is higher; more social issues have emerged. However, the learning disabilities teacher and school counselor continue to provide emotional support for us all and we are convinced that we will end the year successfully. Battle scars do heal and we do become stronger and wiser after each of our challenges with our son.

In Closing

This mom has completed quite a journey over the past few years, one I didn't anticipate as a prospective mother. But, I believe I'm a better parent because of the lessons I've learned and a better helping professional, as well.

Continued on page 3

Book Review

Zipper: The Kid with ADHD

by Caroline Janover (Woodbine House, 1997) (Interest/reading level: Grades 3-6)

Reviewed by Alan Brue

This book tells the story of Zachary "Zipper" Winson, a fifth grader with Attention Deficit Hyperactivity Disorder (ADHD). He is a bright boy with good intentions who always seems to get into trouble at home, in school and on the school bus. Zipper's impulsivity and inability to remember things, such as chores or an important baseball game, frustrate his family and friends. He often alienates himself from his classmates because of poor interpersonal relations.

Zipper befriends Pete Hobson, an elderly resident at a local retirement home. Pete is a former professional musician and a major source of inspiration for Zipper's budding musical hobby. He has a positive influence on Zipper, who performs chores and sells iced tea to finally earn enough money to rent a set of drums for the summer. Things turn around for Zipper: He begins to relate better with his friends, hits a home run that wins the game for his team, and begins to understand his disorder.

The book offers several positive views, such as the effectiveness of teamwork, valuing others despite their disability and the worth of older persons. The appendix provides answers to frequently asked questions and includes a list of suggested readings for parents, teachers, and children. Although helpful, the book's appendix is lacking in a discussion of alternative treatments for ADHD. While a pharmacological approach is used in the majority of ADHD cases, it would have been nice if other treatments were addressed so that readers could be aware of effective alternatives to medication.

The death of Pete occurs on the third to last page and is not dealt with in any substantive way. Thus, it may be inappropriate for very young or immature children or those who may have recently suffered the loss of a loved one.

Zipper gives children with ADHD a glimpse into the life of another child with the same disorder and should stimulate their interest in reading similar books. The book provides them with an opportunity to empathize with another child while also realizing that they are not suffering alone. Hanover weaves together a story which helps us feel the frustration of dealing with children who have ADHD, yet cheering for them to be successful.

While *Zipper* is costly ($11.95) for a children's paperback, it is similarly priced with other books in this specialized category. For children who seek to read about another child who shares "their" disorder, it's well worth the money. It's a great book for every classroom, too. ♦

Alan Brue, M.A.E., is a school psychologist for the Carrollton City Schools in Carrollton, GA.

■ Parent's Perspective... *from page 2*

It is my hope that by reading this, school personnel will realize that they must take action to assure that the parents of these difficult children are heard. Whether the child is a problem in school, a problem at home or both, the parents' insights and experiences must be heard, understood and taken into consideration when the child's intervention plan is developed. Get to know your students' parents and really listen to what they have to say. Imagine periodically what it might be like to live with that student sitting across from you, and utilize all the skills and resources you have and can "rustle up" to help make that student's life a little easier. Facilitate communication between those parents and the other professionals with whom you work. Be the advocate you'd like to have working for you if you were the "mom" or "dad." ♦

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Leslie Hale, Ed.D., NCSP, is a busy parent, school psychologist and administrator in Bartlesville, OK. This article is excerpted from the original which appeared in ADHD: Resources for School Psychologists *(NASP, 1997) and in the NASP* Communiqué *(February 1997).*

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Attention Deficit Disorder

A Primer for Parents

**by Elaine Morton Bohlmeyer, Ph.D, NCSP,
with the school psychology staff of
Gilbert (AZ) Unified School District**

When a student is not doing well in school, especially if teachers also report that the student doesn't seem to concentrate in class and does not complete or turn in work, the parents may wonder if the child has an Attention Deficit Disorder (ADD). Sometimes such children are labeled "hyperactive," although it now is recognized that children can have attention deficits with or *without* overactive behaviors. It is important for parents to recognize the symptoms of ADD and to work with professionals in making an accurate diagnosis.

Characteristics of ADD

Students who have ADD may display a variety of characteristics, but some of the most common are impulsiveness, inattention, disorganization and distractibility. These children are often described as:

- not thinking before they act
- having difficulty following complex directions
- unable to wait
- having difficulty maintaining attention to tasks that are not basically interesting, such as school work or chores (but they may be able to watch TV or play computer games for hours!)
- unable to comply with a schedule
- frequently losing things

Parents often will say, "Even when I see him complete his homework, it never seems to get turned in." It is as if a "black hole" follows some of these children and swallows their homework and supplies. Some children get into fights often and are avoided or rejected by their peers. Others are very likeable and have many friends, although their friendships usually are not deep and lasting. They may get into trouble in school and in the community for doing things they know they shouldn't do, and they may be either extremely sorry or offer a great many reasons why it wasn't their fault. The child may relate a feeling of being out of control or not being able to stop an activity. Parents may ask, "I know he knows better, and I know he's a good kid; why is he always in trouble?"

Diagnosing ADD

Many of the symptoms associated with ADD also may be symptoms of other childhood problems such as depression, anxiety or conduct disorders. Another problem with diagnosis is that there is no blood test or other specific medical test for ADD. Physicians and psychologists who diagnose ADD use observation, behavior reports from people who know the child well and a careful history. Sometimes there is a family history of ADD. In addition, the child's personal history is important because symptoms of true ADD will be present in a child before age seven and will be persistent over the years. If a child suddenly begins to exhibit these symptoms, especially if the child is older than seven, the behavior usually is a temporary response to something that is troubling him or her; however, it also may be the beginning of a deeper emotional problem.

Helping Children with ADD

Treatment of ADD is most successful when a variety of approaches are taken. First, it is important for parents to obtain as much information as possible about ADD. They can attend support groups in their school or community and there may be lectures and seminars provided by their school or mental health agencies. It helps for parents to meet together to learn that they are not alone with this problem and to discuss what other parents have found helpful. The school psychologist should be able to provide information about various resources and reading material.

Second, it usually is helpful for the child to have some individual or group counseling. Counseling may include information about ADD, social skills training and techniques that help the child remember to focus and think before acting. Older children may be taught strategies that will help them organize and complete tasks, such as using notebooks, checklists or timers.

Third, behavior techniques used by parents and teachers can help the child be more successful in meeting the demands of tasks. Since most ADD children really do want to behave well and to be able to finish assignments, they may respond to a prearranged nonverbal signal to return to their work. Positive reinforcement (praise, rewards) for following instructions and completing work may be helpful, but such reinforcement needs to be immediate and frequent. Children with ADD do not respond well to long-term rewards; opportunities to earn rewards need to be given every few minutes for preschoolers, several times a day for young elementary school children and at least daily for adolescents. Other specific techniques include:

- give the child only one or two steps of a direction at a time
- break a school assignment into several short assignments that an adult checks after each part is completed
- set a timer for a short period of time and challenge the child to see how much of a task can be completed before the timer goes off
- help the child to keep a daily calendar
- help the child to organize homework into a notebook

Using Medication for ADD

Finally, a physician might choose to prescribe medication. ADD is a neurobiological condition and medication helps the child to focus and benefit from instructional and behavioral support. Although some parents are reluctant to give their children medication, research shows that other treatments without

the medication component rarely have lasting effects.

A great deal has been learned about ADD during the past five or ten years, so it is important to know what information is current and what is outdated. For example, professionals used to believe that children "outgrow" ADD at puberty and that medication and other treatments were not needed after that time. It now is known that, while most children do outgrow the excessive motor activity often associated with ADD, many people retain other symptoms throughout their adult lives and continue to respond favorably to counseling and medication. There is also evidence that some popular treatments, such as biofeedback, special diets and herbs, are ineffective. Until recently, it was thought that medications used for ADD might permanently stunt children's growth or worsen symptoms of Tourette's Syndrome (such as tics), but new information does not support these fears.

What if I Suspect My Child Has ADD?

If you suspect your child has ADD, you can expect the school to help you by providing behavior reports from teachers, either in written summaries or in the form of structured questionnaires or rating scales. If you have concerns about your child's academic progress or behavior, the school also should investigate whether or not symptoms of learning disabilities or emotional disorder are present. If your child is diagnosed as having ADD, the school is obligated to make reasonable accommodations for the child's condition, such as preferential seating or giving the child more time to complete assignments.

To pursue medical treatment, be sure to see a physician who is knowledgeable about ADD and medications. Work with your physician to find the right medication and the right dosage for your child. It was once thought that dosage should be dependent upon body weight, but now it is known that each child responds differently to dosage level. During the time of adjustment, remember that most medications prescribed for ADD are short-acting and any undesirable (as well as favorable) effects wear off quickly. That is why many of these medications must be taken every few hours. If, however, your child also is being treated for other conditions, such as depression, the effects of medication for these other conditions may be longer-acting. Be sure to discuss side effects with your physician and report any concerns immediately!

Expect the school and physician to work together and communicate regarding the effectiveness of behavior techniques and response to medications. Both educational and medical professionals have unique contributions to make in the treatment process. While reports from school are crucial for monitoring the effects of medications, nobody in the school setting is qualified to prescribe them or change the dosage. While the physician may give helpful educational recommendations, it is not within the authority of a physician to prescribe specific tests or treatments within the school setting.

If your child is diagnosed as having ADD, remember that this condition likely can be fairly well controlled, but it also probably will be a life-long condition. Despite the best treatment, your child may never be as organized and methodical as typical peers. For example, do no expect your child to remember to take medication according to the prescribed schedule unless he or she clearly has demonstrated the ability to do so. Remember that, when your child needs the next dosage of medication, the effects of the last dosage are wearing off and that this is when the child tends to be least well-organized and responsible. Your child may always need more that the usual amount of help to organize tasks and materials, and he or she may never conform to rules and regulations as closely as you would like. However, if you emphasize the child's unique strengths and abilities, the disability may not seem so frustrating. ♦

Resources for Parents

CHALLENGE Newsletter, Challenge, Inc., P.O. Box 488, W. Newbury, MA 011985; $25/yr. A national newsletter on Attention Deficit Disorder published six times a year.

Garber, S.W., Garber, M.D., & Spizman, R.F. (1993). *If Your Child is Hyperactive, Inattentive, Impulsive, Distractible...* New York: Villard Books.

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Maxey, D.W. (1993). *How to Own and Operate an Attention Deficit Kid*. Roanoke, VA: CHADD Support Groups.

Moss, R.A. with Dunlap, H.H. (1990). *Why Johnny Can't Concentrate*. New York: Bantam Books.

Silver, L.B. (1993). *Dr. Larry Silver's Advice to Parents on Attention-Deficit Hyperactivity Disorder*. Washington, DC: American Psychiatric Press, Inc.

Organizations

ADAPPT: Attention Disorders Association of Parents and Professionals Together. P.O. Box 293, Oak Forest, IL 60452 (Publishes *ADDaptibility Newsletter*)

CHADD (Children and Adults with Attention Deficit Disorders). 499 NW 70th Ave. #109, Plantation, FL 33317. (305) 587-3700.

Reprinted from Helping Children at Home and School: Handouts from your School Psychologist (© *NASP, 1998*).

Information for parents, families and educators from NASP's Mental Health and Education Center at:

www.naspweb.org/center/index.html

Position Statement on Students with Attention Problems

The National Association of School Psychologists advocates appropriate educational and mental health services for all children and youth. NASP further advocates noncategorical models of service delivery within the least restrictive environment for students with disabilities and students at risk for school failure.

NASP recognizes that some students with academic and adjustment problems exhibit a constellation of behaviors commonly associated with Attention Deficit Hyperactivity Disorder (ADHD). NASP believes that these behaviors exist along a continuum from mild to severe and that appropriate interventions will vary depending on the nature and severity of the behaviors of concern.

Longitudinal data suggest that the behaviors associated with ADHD typically present at an early age, may change over time, and may persist into adulthood. Therefore, NASP believes that interventions must be designed within a developmental framework. Furthermore, recognizing that these students are at particular risk for developing social-emotional and learning difficulties, NASP believes problems should be addressed early to reduce the need for long-term special education. NASP believes that students with severe attention problems can be provided appropriate special education services under current disability categories of the IDEA or with accommodations in regular education through Section 504 of the Rehabilitation Act of 1973.

Diagnosis of ADHD should be done with care and with the understanding that attention problems are also symptoms of other psychological conditions. Because attention problems can co-exist with other significant problems or be symptomatic of very different disorders, it is essential that a thorough, differential evaluation be conducted prior to diagnosis and treatment, and that this assessment should include direct input from school and home. Further, NASP strongly believes that assessment of attention problems should be linked to interventions and recommends that intervention assistance to students, teachers and parents is provided early and for as long as such support is necessary to assure optimal performance.

NASP believes that effective interventions should be tailored to the unique strengths and needs of every student. For children with attention problems, such interventions will often include the following:

1) Classroom modifications to enhance attending, work production, and social adjustment;

2) Behavior management systems to reduce problems in areas most likely to be affected (e.g., unstructured settings, large group instruction, independent seatwork, etc.);

3) Direct instruction in study strategies and social skills, with explicit strategies for enhancing generalization to natural environments such as the classroom, playground, etc.;

4) Collaboration and consultation with families to ensure that parents' expertise in managing their child is fully utilized, to support parents' behavior management at home, and to facilitate the use of consistent approaches across home, school, and community settings;

5) Monitoring by a case manager to ensure effective implementation of interventions, to provide adequate support for those interventions, and to evaluate the effectiveness of programs in meeting behavioral and academic goals;

6) Education of school staff in characteristics and management of attention problems to enhance appropriate instructional modifications and behavior management;

7) Access to special education services when attention problems significantly impact school performance;

8) Collaboration with community agencies providing medical and related services to students and their families.

9) Interventions to help these students to appreciate their unique abilities and to develop their self esteem.

Research indicates that medication can be an effective treatment for many students with attention problems and can enhance the efficacy of other interventions. NASP believes that a decision to use medication rests with parents and is not an appropriate contingency for school placements and interventions. A thorough, differential assessment is essential prior to pharmacological intervention to assure that the most appropriate medication (if any) is prescribed. Furthermore, medication should be considered only after attempting or ruling out alternative, less invasive treatments. When medication is considered, NASP strongly recommends:

1) That behavioral and academic data be collected before and during blind medication trials to assess baseline conditions and the efficacy of medication; and

2) That communication between school, home, and medical personnel emphasize mutual problem solving and collaborative teamwork; and

3) That the student's health, behavior and academic progress while on medication are carefully monitored and communicated to appropriate medical providers.

NASP believes school psychologists have a vital role to play in developing, implementing, and monitoring effective interventions with students with attention problems. As an Association, NASP is committed to publishing current research on ADHD and to providing continuing professional development opportunities to enhance the skills of school psychologists to meet the diverse needs of students with attention problems. ♦

This revision was adopted by the NASP Delegate Assembly, July 1998.

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The Natural and Logical Increase in ADHD

by Peg Dawson, NCSP

I have been driven throughout my professional career by a desire to help create schools where children are treated as individuals and where instruction is tailored to the needs of individuals. I keep thinking that it's possible to design classrooms that recognize that the children who walk through the schoolhouse door are as varied as the colors in the rainbow. I have this vision of classrooms where diversity is treasured rather than seen as a reason for recommending retention, tracking or special education. By specializing in ADHD, I have been able to spend a lot of time thinking about the kinds of classrooms that work for kids and how to go about making these classrooms happen.

I have talked with school psychologists who groan about being inundated with ADHD referrals. I figure there are two ways of responding to this kind of trend. We can moan and groan about it and ask, "Why won't this epidemic go away so that I can get back to my real work?" Or we can say, "This is my real work, and this epidemic is a perfect opportunity to put my wide-ranging school psychology skills to work."

ADHD as a New Discipline

Let's begin by getting a quick snapshot of what an attention disorder is. I know you've seen the DSM-IV definition — maybe you can quote it as I can — but let me give you a shorthand definition:

> "ADHD: A biological variant made manifest by the affluent society's insistence on universal literacy and its acquisition in a sedentary position."
>
> —John Werry.

With this frame of reference, let's talk about why we're seeing so many more of these kids than we were 5 or 10 years ago. To answer this question, I want to take off from an article Dan Hallahan published in the *Journal of Learning Disabilities* in 1992 entitled, "Some Thoughts on Why the Prevalence of Learning Disabilities Has Increased." I'd seen the article when it first came out and then couldn't track it down last year when I wanted it. So I wrote Dan (my former dissertation adviser) requesting a copy. I mentioned in my letter that I thought it had some application to attention disorders. When he sent me the article, he agreed. In fact, he said the points he made in the article might fit ADHD better than learning disabilities.

Hallahan speculated that two primary factors influenced the increase in LD identifications between 1976 when Public Law 94-142 was implemented and the early 90's when his article was published. First of all, he described LD as a relatively new discipline. The federal government started keeping statistics on the numbers of students with handicaps served by special education in 1976. Hallahan pointed out that this was only 7 years after the formation of the field of learning disabilities. Thus, the increase in numbers of children identified as learning disabled is likely due primarily to a growing awareness of the disability rather than a misuse of a label. In 1976, about 24% of children with disabilities were LD; in 1994 (the last year for which I found statistics), 51% of all children with disabilities were LD. While it seems like LD may be over-represented, according to Hallahan, this represents only 4.66% of the school-aged population. Given the complexities of learning and how many things can break down, this may not be a particularly high figure.

ADHD has undergone a similar development. It, too, is a new field. The term wasn't even around in 1976; and it was only following the issuance of the Federal memorandum clarifying Federal policy regarding services to children with attention disorders that states began identifying children as Other Health Impaired to any substantial degree. The 26% increase in the category from the 1992-1993 school year to the 1993-1994 school year is likely in large part attributable to the Federal memo which informed school districts that the OHI (Other Health Impaired) category could be used as an umbrella for providing services to children with ADHD.

One could argue that these kids have always been around, they were just called something else back when you and I went to school: delinquents and trouble-makers if they fell in the ADHD, Predominantly Hyperactive category, or lazy and unmotivated if they fell in the Predominantly Inattentive category. So now we have different names for age-old conditions, and we can certainly debate whether the name ADHD is better than trouble-maker or lazy. Concisely, my own feeling about the label is this — and I tell this to the parents and kids that I see, as well as to my own son with an attention disorder: ADHD is an explanation, it's not an excuse. It's a way of understanding and acknowledging that what is hard for you is *truly* hard for you (whether it's paying attention, making yourself sit through boring classes, stopping yourself from saying stupid things, or making yourself do your homework). But the bottom line is that, because it's hard for you, it means you will have to work harder than the average student to overcome these obstacles.

The Influence of Culture and Society

But let's face it. This doesn't fully account for the increase in numbers of ADHD referrals schools have seen in recent years. And here's where Hallahan's second factor comes in. He maintains that there have been profound social and cultural changes which have influenced the prevalence of learning disabilities. And he feels this is true in two ways: "First, social/cultural changes have put the development of children's central nervous systems at increasing risk of disruption. Second, they have placed an increasing degree of psychosocial stress on children and their families: a stress that has had deleterious consequences for children's social support networks." Certainly these same arguments could be applied to ADHD.

Before I elaborate on those points, let me cite one more quote from the Hallahan article that I think is particularly germane: "Of all the categories of disability, learning disabilities [and I would argue, attention disorders] is one of the most sensitive barometers of the biomedical status of children and the psychosocial climate in which they live. In other words, if you take the human organism and subject it to biological or psychological stress, it will usually take less of that stress to result in a learning disability (or an attention disorder) than to result in another type of disability (e.g., mental retardation, behavior disorder)." Hallahan goes on to point

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out that evidence for this comes from the fact that, regardless of disability category, there are more individuals that are mildly affected than severely affected. And he considers LD (and again, one could add ADD) to be a mild disability, when you consider the broad spectrum of disabilities.

Certainly, if you consider a learning disability to be a central nervous system disorder, the same could be said for ADHD. PET scans and other studies have targeted the frontal lobes of the brain to be where "attention" resides. And attention is particularly vulnerable to dysfunction for several reasons. First of all, it is one of the last parts of the brain to develop during the prenatal period, thereby making it more susceptible to negative influence during the last trimester as well as during birth and early infancy. It also stands to reason that of all aspects of brain functioning, attention is most likely to be affected by poor prenatal care and other effects of poverty, by drug or alcohol abuse, or by exposure to environmental toxins such as pollution and lead poisoning.

And, secondly, experts in traumatic brain injury will tell you that the frontal regions of the brain are most likely to be injured in the most common types of accidents that result in head injuries. And it may take a relatively minor accident to produce permanent damage.

Hallahan makes similar arguments with respect to learning disabilities. But he goes on to talk about other influences. He says, "At the same time that social/cultural forces are having a negative impact on the CNS development of more and more children, some of these same forces are making it more difficult for children to overcome any CNS inadequacies that they may already possess." He talks about significant increases over the past 20 to 40 years in poverty, single teenage mothers, drug abuse and homelessness. Those are obvious. But he also maintains that the social support networks of middle and upper middle class children have also become less secure.

We know, for instance, that American adults are working more hours rather than less, are more likely to be holding down more than one job, and are more likely to be in families where both parents work than a generation ago. I also suspect, though I've not seen statistics to bear this out, that adults are spending longer hours commuting farther distances to work than they used to.

There are also more single parent families and more children living in joint custody arrangements, both of which complicate schedules and increase the demands for planning and organization in families. All of this also contributes to general stress in the adult population which necessarily spills over to their children. A study published in the *Annals of Internal Medicine* in 1995 cited a survey that found that 24% of adults polled complained that they suffered from fatigue that lasted two weeks or longer; nearly two thirds reported that their exhaustion had no medical cause. I read this in an article in the *Washington Post National Weekly Edition* which caught my eye because of the headline: "Everybody's Pooped."

In addition to the lives of adults becoming more complex, the lives of children are also becoming more complex. A few years ago I remember talking to my father about my work. After I described the kinds of kids I work with, he said, "I was probably one of those kids when I was in school." I thought about that for awhile and then said to him, "You made it through school okay, how do you explain that?" His answer was revealing: "I grew up in the Depression," he said. "When I got out of school in the afternoon, what options did I have? I could play in the woods behind my house, I could read books, or I could do my homework."

My father grew up in White Plains, New York, a relatively affluent suburb of New York City. Can you even begin to imagine the choices available to kids in White Plains today? In addition to a million after-school sports and extracurricular activities to choose from, kids can go home and turn on the television with its 100 cable channels, turn on the computer and surf the net endlessly, or turn on any of a number of video game systems and play games for hours that are pointless but which at the same time are novel and exciting. When my father was growing up in the 30's — and even when my brothers and I were growing up in the 50's — the fun stuff was somewhere in the distant future, when we were grown ups. Nowadays, the fun stuff is right now! No wonder so many children find it hard to resist.

The technology available today offers children the opportunity to be both more actively involved in learning (such as with the Internet or computer games) and more passively involved (those 100 cable TV channels). Children end up being both better problem solvers and bigger couch potatoes.

Think of the environmental influences on attention. We have shaped children to have shorter attention spans. Starting with *Sesame Street*, we teach children that if they wait a minute, something new and different will come on the screen. Just as infants are drawn to novel stimuli, so are preschool television viewers. And nothing in their television future will do much to alter that attention span. Is it any wonder that when they come to school, they expect to be entertained by sound and sight "bites" that don't tax their concentration? Is there anything in the way our society is structured today that tells children to "slow down, take your time, pause and reflect?" Is not an attention disorder a logical outcome of our high speed/high stimulation society?

Hallahan maintains that these profound societal changes have stressed the social support networks available to families. The fragile supports for families then interact with relatively mild impairments to cause more substantial learning or attention problems. This makes sense to me. He also maintains that homework today is more demanding and more complex than it used to be. So parents, who have less discretionary time than they did a generation ago, are having to spend more time working side by side with their children to ensure that homework gets done. Furthermore, the complex problems with scheduling, transportation and after school activities, along with the fact that children are changing classes and having multiple teachers at younger ages than they used to when we were growing up, exacerbate homework problems. It's too hard to keep track of everything, too easy for something to drop out of sight.

Vygotsky's Perspective

I want to provide one additional perspective. This comes from Vygotsky, the great Russian developmental psychologist and "constructivist." Whereas behaviorists believe that behavior is shaped primarily as a result of external contingencies in a fairly mechanistic stimulus-response sequence — or perhaps an antecedent-behavior-consequence sequence if you want to make it a little more complicated, constructivists believe that people play a more active role in constructing their reality. They respond to external

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Medical Management of Behavior and Emotional Problems in Children and Adolescents

A Primer for Educators

by Servio Carroll, Ed.S., NCSP

Overview

The use of medication for treating children and adolescents with behavior and emotional problems has increased in the last fifteen years due to the availability of new, more effective and safer medications. Research supports the biochemical basis of many conditions once thought to be based only in dysfunctional family relationships or environmental stress. It is estimated that 2 to 3% of all school children, and 15 to 20% of those in special education classes, are taking mental health (psychopharmacologic or psychotropic) medications at any given time. Still, using this type of medication with school-age children remains a highly controversial topic. Opponents argue that quality educational programming for children and adolescents with behavior and emotional problems is being replaced by attempts to find a quick cure through drugs, and note that many drugs now prescribed for children were approved only for adults. However, public schools today are successfully educating children who not long ago were in special schools or housed in state hospitals. Properly used, medications can increase the success of nonmedical interventions, enhance quality educational programming and allow a student to be educated in a less restrictive, home-school environment.

Commonly Used Psychotropic Medications

Drug research is a rapidly changing science, and research findings supporting new uses for standard medications are common. The U.S. Food and Drug Administration (FDA), recognizing that established regulatory practices cannot keep up with medical research, agreed with the American Medical Association to allow physicians to prescribe any medication approved for marketing for "unapproved" purposes (such as with children) or dosages as they see fit. The FDA is encouraging research to establish the effects of adult approved medications such as anti-depressants on children. Meanwhile, millions of young patients are treated with a variety of psychotropic medications, and new medications are introduced every year.

There are four major categories of psychotropic medications used with children and adolescents: stimulants, antidepressants, neuroleptics and anticonvulsants.

Stimulants are the best studied, best validated and most controversial medications used for treating Attention Deficit Hyperactivity Disorder (ADHD). It is estimated that 2% of the school-age population receives stimulant medication for ADHD. *Ritalin* (methylphenidate), *Dexedrine* (d-amphetamine) and *Cylert* (magnesium pemoline) have been the medicines of choice for many years. Some children respond better to one stimulant over the other, and some children do not respond to any of them. It's unpredictable, but most students continue to benefit from stimulants into adolescence and even into adulthood. A new arrival to the field is *Adderall* (a combination of amphetamines) with possible advantages over Ritalin in that it is longer lasting and has fewer side effects. The long-acting formulas available have proven to be less effective at maintaining a therapeutic dose throughout the school day in some students.

Stimulant medications' most common side effects are insomnia, decreased appetite, stomach aches, increased heart rate and worsening of symptoms (including tics). These side effects are transient usually, and avoided by starting with low dosages and increasing them periodically until desired effects are obtained. Abuse of stimulant medication by adolescent patients has been reported but remains to be substantiated by adequate research. A valid concern with stimulant medications is that as the dosage needed to control hyperactivity increases, learning performance decreases in some children. Pediatricians must be cautious in prescribing and main-

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stimuli, but they filter it through their own idiosyncratic filtering mechanisms to derive their own definitions of what is real. Vygotsky talks about this in terms of a "situation definition" and maintains that, in order for good teaching to take place, a teacher must understand a student's unique situation definition before he or she can hope to influence that student to acquire the more sophisticated understanding required when learning new concepts.

How does this relate to attention disorders? The behaviorist in me has generally attributed the growth in attention disorders to effects of changing reinforcement contingencies. The brain stays the same, it's the environment that's changed. So, if we want to reduce the numbers of kids with attention problems, we need to change the reinforcement contingencies. Vygotsky, however, suggests that learning and development can only be understood within an historical context. He goes on to postulate that "higher mental functions are socially formed and culturally transmitted: 'If one changes the tools of thinking available to a child, his mind will have radically different structures.' "

By providing children today with such a complex and stimulating array of choices, by giving them tools such as computers, cable television, video game systems — all of which have altered the speed and manner with which knowledge and experience are acquired, are we, in fact, altering brain structures? Is the "ADHD" child of today the "normal" child of tomorrow?

If so, that supports much more strongly the need to promote classrooms that respond better to how kids today really think and learn. ♦

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taining the dosage that enhances learning, although it may not remove all of the symptoms of hyperactivity.

Opponents of stimulants to treat ADHD also argue that, while stimulant medications may enhance attention span and improve productivity, they do not produce significant gains in achievement. Clearly, stimulant medications are not "cognitive enhancers," but many students can work closer to potential in academic subjects when they can block out distractions and focus their attention on the task.

Although not an FDA-approved use, stimulant medications are being prescribed to treat ADHD-like symptoms in below average students, preschool children, children with Fragile X syndrome, autism and Tourette's syndrome. However, great care must be taken in treating Tourette's Syndrome with stimulants, as some (such as Ritalin) have been shown to increase tics. Recent research reports "clinically modest positive effects" when Ritalin is combined with desipramine (an antidepressant) in treating behavior and mood disorders. Also, Cylert has been effective in reducing negative behaviors in some adolescents diagnosed with conduct disorder. Another antidepressant medication, Welbutrin (bupropion), was found as effective as Ritalin in the treatment of ADHD when rated by teachers and parents in well-controlled studies. These findings are significant and add to the physician's ability to combine medications to increase desired results while decreasing side effects.

Antidepressants are prescribed to treat depression. They are also the second most often prescribed medicine for the treatment of ADHD, and are being used successfully with Obsessive Compulsive Disorder and school phobia. Antidepressants are divided into three categories: tricyclic (TCA), monoamine oxidase inhibitor (MAOI, aka MAO) and novel or atypical.

Tricyclics have been around for over fifty years. TCAs are effective in treating major depressive disorders, anxiety disorders, panic disorders and generalized disorders in adults. TCAs are relatively safe, effective and easy to administer, but are not quite as effective with children and adolescents.

The FDA has only approved TCAs for the treatment of bedwetting and ADHD in children. *Imipramine (Tofranil)* continues to be the drug of choice for bed-wetting, but behavior management still offers a lower relapse rate and best long-term results. Current research and practice suggest that TCAs may also be indicated for the treatment of school phobia, obsessive compulsive disorder and generalized depression in children and adolescents. Research also supports the use of TCAs in combination with other stimulants, neuroleptics and anticonvulsants to treat a variety of psychiatric diagnoses.

TCAs' side effects include irregular heart beats, low blood pressure, seizures, insomnia, confusion, tremors, anxiety and others. As true with any medication, careful monitoring of children and adolescents taking TCAs is very important. Physicians prescribe this medication under close supervision.

MAOs have also been around for over sixty years, but are seldom used today. Newer medications have fewer side effects, patients do not have to follow a strict diet, and are easier to monitor. Currently no MAO compound is approved by the FDA for use with children under age 16 because of probable liver problems. In older adolescents, MAOs could be useful when other medications have failed in treating atypical depression, social phobia and borderline personality disorder with depression.

Novel/atypical: The newer antidepressants, called Novel or atypical are *Selective Serotonin Reuptake Inhibitors (SSRI)* and others in class of their own. *Prozac (fluoxetine)*, *Zoloft (sertraline)*, *Paxil (paroxetine)* and *Luvox (fluvoxamine)* are in the SSRI group. Also included in the Novel category are non-SSRIs *Welbutrin (bupropion)* and *Desyrel (trazadone)*. While there are no FDA-established indications for SSRIs in treating children and adolescents, possible indications include major depressive disorder, ADHD, Obsessive Compulsive Disorder, poor impulse control, self-injurious behavior, post-traumatic stress disorder and eating disorders.

Prozac has become the drug of choice in treating adults because of its relative lack of side effects and withdrawal symptoms. Prozac has also been effective in treating ADHD, but it's a costly alternative. *Luvox* has been effective in treating Obsessive Compulsive Disorders. *Welbutrin* has also been used with success to treat ADHD in children and adolescents and is being used experimentally to treat major depressive disorders in this population. *Desyrel* is not routinely prescribed for children and adolescents. However, Desyrel is a good choice for adolescents who are at risk of overdosing, because it has a low toxicity level. Desyrel is also useful to treat depression with anxiety-related insomnia. Used in combination with TCAs, SSRIs appear effective in the treatment of childhood anxiety disorders, with few side effects. The possible side effects — seizures, agitation, sedation, insomnia, weight loss, hair loss, headaches, nausea, etc. — can be serious, which supports why SSRIs should only be used in carefully controlled settings with children and adolescents.

Neuroleptics are antipsychotic agents and are also called major tranquilizers and anti-confusional agents. They are mostly used with adults, but the FDA has approved some to used with children less than 12 years of age. These medications are indicated for a variety of emotional and behavior problems including severe psychosis, mania, Tourette's Syndrome, autism, Pervasive Developmental Disorder and self-injurious behavior in school settings. *Thorazine (chlorpromazine)*, *Mellaril (thioridazine)*, *Navane (thiothixene)*, *Haldol (haldoperidol)*, *Compazine (prochlorperazine)*, *Respirdal (respiridone)* and *Clozaril (clozapine)* are the most commonly used medications of this type. These medications' side effects include sedation, mood blunting, lethargy, heart arrhythmia, cognitive dulling, poor muscle tone, tardive dyskinesia, liver toxicity, sudden death, weight gain and a negative effect on attention and learning. The risks of using antipsychotic medications in the treatment of emotional and behavior problems in children and adolescents without psychosis may be difficult to justify unless it can be clearly shown that the medication makes a major and clinically important difference. Two new medications, *Respirdal* and *Clozaril* have shown promising results with relatively few side effects, but are still considered as experimental in children and adolescents.

Adolescents showing the typical bipolar (manic-depressive) disorder can respond to *Lithium*. Children rarely present with mania but can show cyclic mood and behavior shifts with periods of impulsivity, social intrusiveness, tantrums and mood lability, which sometimes respond to Lithium. Lithium therapy is not FDA-approved for children less than 12 years of age. A major drawback of Lithium is the need for careful monitoring through blood tests, but studies are being conducted to measure Lithium levels through saliva.

Recent Lithium studies have demonstrated that when combined with TCAs Lithium increases the effects of TCAs and can bring relief to patients with major depressive disorders that have not responded to TCA therapy alone. Lithium has also been effective in treating conduct disorders in adolescents when aggressive and explosive behaviors are present. Lithium may be the medicine of choice with aggressive and explosive mentally impaired patients, with fewer side effects than Haldoperidol. In controlled medication trials with anorexia nervosa patients, those who received Lithium gained more weight than those who received a placebo. Lithium, although used for over forty years to treat bipolar disorders, shows promise as a medicine of choice in treating other conditions which have been difficult to treat.

Anticonvulsants are prescribed to treat seizure disorders, but in the last fifteen years there has been a growing trend to use this type of medication to promote mood stabilization. Research has supported the use of *Tegretol (carbamazepine)* in patients with bipolar (manic-depressive illness) disorders, particularly in acute mania. Two other anticonvulsant compounds, *Depakote/Depakane (valproic acid)* and *Klonopin (clonazepan)* have also received a lot of attention. The literature supports the use of Tegretol and Depakote/Depakane as good agents to control manic episodes, rage outbursts, aggression and conduct disorder. The fact that these three medications have the potential for fairly severe long term side effects, such as liver failure, tremors, bone marrow damage, has kept the FDA from approving them for this use. Nevertheless, anticonvulsants are being used today to treat bipolar disorders, major depression, ADHD, conduct disorders and sleep terror disorders in children and adolescents. Supporters of these medications maintain that the serious side effects can be averted by careful laboratory monitoring.

What Can I Do As a Teacher?

The growing trend is to use medication to control certain behaviors in children and adolescents with behavior and emotional problems. Educators are quick to list cases in which medication has had a Jekyll and Hyde effect, making unmanageable children teachable almost overnight. There is little doubt that some medications have proven effective in treating certain conditions. Yet, we must keep in mind that the newer drugs are rarely studied in children or adolescents before marketing, and even the older drugs have been only partially studied in this population. Many mental health medications being used today are still in the experimental stage and should be reserved for clearly distressed or dysfunctional conditions where other treatments have either failed or are only likely to produce short-term results. Medical management of behavior and emotional problems is sometimes justifiable, but there should be strong clinical evidence or benefit. Trials off medication are often indicated to insure the medicine is still making a useful educational difference.

Drug therapy for children and adolescents remains an individual and personal decision between the parents and their physician. Educators should refrain from recommending medicines or dosages with parents unless they have had training in psychopharmacology. Educators, however, are an integral part of the treatment team since proper medication management requires close collaboration between the physician, the parents and school personnel. Effective close collaboration means that each team member:

1. understands the treatment plan and goal(s);
2. is aware of expected behaviors at each step of the treatment plan;
3. knows the possible and probable side effects of the medication(s);
4. knows how to recognize and respond to serious adverse reactions;
5. follows the plan; and
6. remains available to the other team members.

Parents and teachers must remain alert to situations in which medications are being used inappropriately and instead of appropriate educational programming and placement. ♦

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Servio Carroll, NCSP, is a school psychologist in Sheridan, WY. *Some of the material for this handout was adapted from Forness et al. (1996), noted in the resource list above, and from material developed by Susan Vess, Ph.D. of the University of Southern Maine. Reprinted from* Helping Children at Home and School: Handouts from your School Psychologist *(© NASP, 1998).*

NASP Mission Statement

The mission of the National Association of School Psychologists (NASP) is to promote educationally and psychologically healthy environments for all children and youth by implementing research-based, effective programs that prevent problems, enhance independence, and promote optimal learning. This is accomplished through state-of-the-art research and training, advocacy, ongoing program evaluation, and caring professional service.

Attention Disorders: Interventions for Adolescents

by Peg Dawson, NCSP & Richard Guare

Areas of Difficulty	Possible Interventions
Organization	
Doesn't do homework	Homework Survival Guide (*Communiqué*, June 1994) Incentive system Supervised study hall Alternative homework assignments Self-designed homework After school homework sessions in school
Loses homework/possessions	Daily check-ins (home/school) — monitoring system Organizational aids (checklists/reminders/routines) Targeted incentive system
Doesn't come to class prepared	Case manager or other monitoring system Spare materials in classes students can borrow/rent Targeted incentive system
Disorganized notebooks	Monitoring system (e.g., daily notebook check) Don't penalize (e.g., grading modifications)
Messy work	Computer access Specify clear criteria — have student redo if work doesn't meet criteria Incentive system Modify expectations
Planning	
Prioritizing	Students with attention disorders need assistance in these areas and cannot be expected to perform these skills without adequate instruction and practice. This could occur in planning periods built into the student's day. Instruction may follow a sequence such as: 1) define skill to be learned; 2) model skill; 3) have student engage in verbal rehearsal; 4) guided practice; 5) independent practice with follow-up. A second option is the use of a coach (described in Hallowell & Ratey, *Driven to Distraction*).
Remembering	
Handing in assignments	Case manager to monitor Home/school daily check-in Incentive system
Knowing when things are due	Case manager to monitor Home/school daily check-in Incentive system
Bringing materials to/from school	Case manager to monitor Home/school daily check-in Incentive system
Math facts/other rote memory tasks	Memory aids Allow use of calculators Reduce demands/expectations
Sequence of steps to follow (e.g. math)	Construct personalized instructional manual with templates, directions, examples of problems, models, etc.

Areas of Difficulty	Possible Interventions
Following Directions	
Verbal	Provide study partner Repeat directions individually
Written	Check-in with student/clarify as necessary Highlight directions for student/have student highlight
Written Production	
Poor fine motor skills/ motor impersistence	Allow to dictate written responses Allow the use of tape recorders Access to computers for writing assignments Reduce writing requirements
Discrepancy between thinking/ writing speed	Access to computers/recorders Opportunity to respond orally
Difficulty organizing thoughts	Assistance with prewriting activities (e.g., brainstorming, mind mapping, outlining) Writing ideas on post-its, rearranging to outline
Problems with initiation/word retrieval	Brainstorming vocabulary, key concepts Helping getting started Close-ended writing tasks
Proofreading problems	Use spellcheck Have another student/adult proofread Use proofreading checklist to cue for specific errors
Problems with Test-Taking	
Careless mistakes	Allow test re-takes Supervise checking work
Can't finish within time limits	Allow extra time Break testing into several sessions
Writing problems	Oral exams Short answer/multiple choice vs. essay Reduce demands/allow extra time
Distracted during testing	Let student take test in quiet room
Anxiety	Teach test-taking strategies Teach relaxation strategies Let student take test away from other students
Difficulties with retrieval	Multiple choice tests Open book tests Provide sample items/templates Cues to aid retrieval during test Teach test-taking strategies
Social Skills	
Impulsive	Consider the following for all social skills problems: Incentive systems
Disruptive	Negotiated behavior contract Match student with teacher
Apathetic	High rate of personalized positive feedback Alternative curriculum

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■ **Interventions...** *from page 13*

Areas of Difficulty	Possible Interventions
Discouraged	Credit for out-of-school learning Work-study programs
Depressed	Hands-on learning
Cognitive Style	
Fast and sloppy	Assign shorter tasks with criterion for accuracy Teach self-evaluation/goal-setting re accuracy or quantity
Problems with initiation	Assign close-ended tasks Provide templates Help student get started (e.g., walk through 1st few items/brainstorm ideas, etc.) Assign study partner Use cooperative learning Assign shorter task/break tasks down Obtain verbal commitments (e.g., re start times)
Low frustration tolerance	Modify assignments Ensure high rate of success Frequent reinforcement Provide individual help Self-designed assignments (brainstorm ideas)
Processing speed/simultaneous processing problems (e.g., can't listen and take notes)	Provide individual help Tape lectures Provide note-takers or access to teacher notes Present material in organized, sequential fashion Reduce assignments/allow extra time
Craves novelty/hates repetition	Avoid lecture style classes Avoid classes with heavy rote learning or worksheet requirements Computers/technology Use cooperative learning Use hands on learning/discussion format Self-designed assignments Individualized work contracts Assign to high energy teachers Avoid needless repetition Build in breaks/opportunities to move around Vary formats within/across class periods ♦

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Peg Dawson, NCSP, & Richard Guare are affiliated with the Center for Attention Disorders *in Portsmouth, NH.* *Reprinted from* Helping Children at Home and School: Handouts from your School Psychologist *(© NASP, 1998).*

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Video Review

How to Help Your Child Succeed in School: Strategies and Guidance for Parents of Children with ADHD and/or Learning Disabilities

by Sandra Reif (Educational Resource Specialists, San Diego, CA 92159; 800-682-3528); VHS — 56 minutes; Cost: $46

Reviewed by Melodie P. Garrett, NCSP

Talking to parents in a user-friendly manner, Sandra Reif has packed into 56 minutes many of the best educational interventions and pragmatic solutions to the home-work chaos that exists in many hurried families today. The introduction is sympathetic to the many conflicts of modern families. This tape does not deal with the controversial positions about cause or incidence of attention disorders or learning disabilities. Difficulties in learning are described as neurologic deficiencies that occur within 10 percent of the population, thereby supporting the CHADD position. A professional that does not support the CHADD position may have difficulty using this introduction with parent groups without addressing these issues before the video is presented.

This video is divided into 5 additional sections dealing with organization and study habits, remediating math, reading and writing, and repairing relationships. The suggestions in each section range from readiness to more abstract lessons. The sections are easily outlined to develop a handout for parents to follow along. Having the break-in sections can lend itself to group discussions that could be more individualized for parents.

As a school psychologist, I would recommend this film for primary and secondary intervention. It would be an excellent workshop for parents of K-1 students, to get them off to a good start when parents are eager to work with their children. As a former learning disabilities teacher, I was using many of these same strategies with good success nearly 20 years ago. As a parent of 5 children with multiple exceptionalities, one criticism of the video is that the "homework settings" visualized are too ideal and might be discouraging for some parents. In my opinion, parents should be urged not to make too many changes in the homework setting at once.

This video might be valuable to parents doing home schooling as well since their interactions are primarily one-to-one. As parents doing home schooling have many different levels to teach, they might easily apply many of these techniques. ♦

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Barkley, R. *ADHD in Adults*. Guilford Press.

Breggin, P. & Valentine, M. *The Myths of ADHD*. Children First, 23565 Via Paloma, Coto de Caza, CA 92679.

Organizations

ADAPPT: Attention Disorders Association of Parents and Professionals Together. P.O. Box 293, Oak Forest, Il 60452 (Publishes ADDaptibility Newsletter).

Attention Deficit Disorder Association (ADDA): 1070 Rosewood, Suite A, Ann Arbor, MI 48104; (800) 487-2282 or (313) 769-6690.

The Attention Deficit Information Network, Inc. (AD-IN): 475 Hillside Av, Needham, MA; 02194; (617) 455-9895.

CHADD (Children and Adults with Attention Deficit Disorders): 499 NW 70th Av #109, Plantation FL 33317; (305) 587-3700. <*http://www.chadd.org*>

Council for Exceptional Children (CEC)/Educational Resources Information Center (ERIC): 1920 Association Drive, Reston, VA 22091; (703) 620-3660; (800) 328-0272. <*http://www.cec.sped.org*>.

National Association for Attention Deficit/Hyperactivity Disorder: 228 Birch Drive, New Hyde Park, NY 11040-2322; (516) 294-5000. <*http://www.attentiondisorder.com/*>

National Information Center for Children & Youth with Disabilities (NICHCY): P.O. Box 1492, Washington, D.C. 20013-1492; (800) 695-0285; (703) 893-6061. <*http://www.nichcy.org*> ♦

Compiled by Elaine Bohlmeyer (Gilbert AZ USD), Deborah Cross (Los Angeles USD), Michael Valentine (Coto de Caza, CA), Marcia Weill (Folsum, CA USD), Michael Wilson (Minneapolis Schools) and Andrea Canter (Minneapolis Schools). Reprinted from Helping Children at Home and School: Handouts from your School Psychologist *(© NASP, 1998).*

ADD Look-Alikes
Guidelines for Educators

by Servio Carroll, NCSP

Background

Due to the wide variety of psychomedical and biomedical problems that can be mistaken for Attention Deficit Disorder (ADD), or that may co-exist with ADD, it is always essential for a child to be carefully evaluated. Medical specialists are working to develop a more precise idea of which hyperactive children and adolescents really have ADD and which have look-alike problems that only resemble this disorder. Look-alike ADD children may fulfill the diagnostic criteria for ADD but have a completely different problem and, therfore, should receive a different diagnosis. These ADD look-alikes are important to distinguish because their long-term course and treatment may be quite different from children with classical ADD. There are several psychomedical problems or medical disorders that can mimic ADD, resulting in an ADD look-alike child.

Depression

Depression is certainly common in adolescents and children, just as it is in adults. While it may seem unlikely that a depressed person would be "hyper" (since many depressed people seem to talk and think slowly and move with great effort), some inattentive children with impulsive and hyperactive behavior are actually depressed. These children may just have passing symptoms of depressed mood (e.g., feeling blue or demoralized) or more persistent or even chronically bad moods (dysthymic disorder), or have the psychiatric diagnosis of depression with its accompanying physical changes (major depression). Even though these children may have prominent ADD-like symptoms, treating their depression is more successful than treating the ADD symptoms.

Stress-induced Anxiety States

Anxiety states caused by environmental stress may present as ADD. Certain children living in a stressful home situation or adolescents dealing with social or academic pressures may look like they have ADD. Obviously, helping them cope with the stress in their lives is preferable to the use of stimulant medications. Even mild stress can produce symptoms that mimic ADD.

Biologically-based Anxiety Disorders

Certain medical disorders such as separation anxiety disorder or obsessive compulsive disorder are treated quite differently from ADD — even though many of the symptoms of these disorders may look the same as ADD symptoms. However, stimulants often worsen the symptoms of these anxiety disorders, which are better treated with different medications and approaches.

Child Abuse or Neglect

In certain circumstances, the victims of sexual abuse, physical abuse or neglect can present with symptoms of ADD. Even after a limited period of abuse or neglect, these children may continue to show symptoms that are difficult to distinguish from ADD.

Bipolar Disorders

Another biomedical condition that may mimic ADD is the family of bipolar disorders. The most severe version of bipolar disorder in adults is manic-depressive illness, but most common bipolar disorders are more mild. Bipolar disorders in children and adolescents can present with impulsivity, inattention and hyperactivity, along with overly strong feelings or an overbearing manner, irritability or unprovoked hostility, and often difficulty in "getting going" in the morning. It is only the more severe forms of bipolar disorder in adolescents and children that show amazingly energized and lengthy temper tantrums with gross destructiveness during their brief or lengthy rages. About half of boys (and perhaps a quarter of the girls) with bipolar disorders fulfill diagnostic criteria for ADD, but bipolar disorder tends to appear in families in which depression or bipolar disorder has emerged before. Although stimulants can sometimes help these children with bipolar disorder, stimulants often make the symptoms worse and can be quite risky. Lithium and other medications can be much more helpful.

Schizophrenia

Schizophrenia is a serious biomedical disorder that can include ADD symptoms. Children with schizophrenia are relatively uncommon, typically come from families in which schizophrenia has emerged before, and represent an extremely small fraction of the children with ADD symptoms. Again, stimulant medications can be risky for these children, and other medications and treatments are strongly preferable.

Other Medical Disorders

Certain medical disorders of sleep (or arousal), malfunctions of the thyroid gland and excessive lead ingestion may also present with symptoms that are typically seen in children with ADD.

Summary: Cautions in Diagnosis and Treatment

Look-alike ADD children may fulfill the diagnostic criteria for ADD but have a completely different problem and, therefore, should receive a different diagnosis. All of the above conditions may cause a child to behave impulsively and show difficulties in attention and hyperactivity that are hard (and perhaps impossible in some instances) to distinguish from ADD. Particularly if a child's situation is worsening with age, it is important to consider the possibility that ADD may not be the sole or even primary problem. Also, if the ADD is associated with bad dreams, bad moods or disturbing thoughts, or if there is a family medical history of psychiatric disorders, then it is important to be sure that mimicking disorders and additional problems are not present.

If a medical or other psychiatric disorder is presenting as ADD, a treatment that merely improves the ADD symptoms may leave a residue of untreated behavioral problems, mood abnormalities or disorders of physiology. In these cases, even if stimulants are helpful or if environmental changes improve the child's

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Helping the Student with ADHD in the Classroom

Strategies for Teachers

by Stephen E. Brock, NCSP

Introduction

Affecting three to five percent of the population, Attention Deficit/Hyperactivity Disorder (ADHD) is one of the most common of the childhood behavior disorders. Associated with this disorder's core symptoms of inattention, hyperactivity and impulsivity are a variety of disruptive classroom behaviors (e.g., calling out, leaving seat, interrupting activities, etc.). Consequently, it is not surprising that these students are at risk for school failure.

Increased expectations for the use of classroom interventions for students with ADHD have been generated by Section 504 of the *Vocational and Rehabilitation Act of 1973* and the *Individuals with Disabilities Education Act* (IDEA) of 1997. Section 504 has been used to require the development of general education accommodation plans. These plans are designed to ensure that the student with ADHD is provided a free and appropriate education. Among the recommended components of these plans are a variety of classroom interventions (including behavior management), with a special emphasis on environmental modifications. Similarly, the recent reauthorization of *IDEA*, with its requirements for functional assessments, should increase the frequency with which classroom-based behavioral interventions are considered for these students.

General Behavior Intervention Suggestions

Classroom interventions for the student with ADHD should be based upon a solid foundation of general behavior intervention principles. While students with ADHD do have a core of common problems, this group is fairly heterogeneous. Thus, instead of focusing on ADHD symptoms, management should first directly target the specific problem behavior. Next, an alternative behavior, incompatible with the problem behavior, should be selected. It is important to keep both behaviors in mind. Not only do we want to make it clear to students what behavior is unacceptable (what we don't want them to do), but we also want to make it clear what behavior is acceptable (what we want them to do). These behaviors should be carefully defined so that the teacher will be able to accurately monitor them.

It is also important to ensure that the behavior intervention plan is based upon a careful functional assessment of behavior. Antecedents and consequences of both the problem and replacement behaviors need to be studied. Antecedents will suggest environmental changes that set up the student for success or failure. Analysis of consequences, on the other hand, will identify those environmental contingencies that serve to reinforce both desired and undesired behavior. The function of the problem behavior should guide intervention plans. For example, if the behavior is maintained by negative reinforcement (e.g., avoidance of an undesired task), then the intervention should ensure that this goal is not obtained by the problem behavior. At the same time the intervention should teach the student that the desirable behavior is a more effective way of obtaining the behavioral goal.

Environmental and Instructional Considerations

Task duration

To accommodate the student's short attention span, academic assignments should be brief and feedback regarding accuracy immediate. Longer projects should be broken up into manageable parts. Short time limits for task completion should be specified and can be enforced with timers.

Direct instruction

Attention to task is improved when the student with ADHD is engaged in teacher-directed as opposed to independent seat-work activities. Also, the teaching of note-taking strategies increases the benefits of direct instruction. Both comprehension and on-task behavior improve with the development of these skills.

Peer tutoring

Class-wide peer tutoring provides many of the instructional variables known to be important in setting up students with ADHD for success. For example, it provides frequent and immediate feedback. When combined with a token economy, peer tutoring has been found to yield dramatic academic gains.

Scheduling

Based on evidence that the on-task behavior of students with ADHD progressively worsens over the course of the day, it is suggested that academic instruction be provided in the morning. During the afternoon, when problem solving skills are especially poor, more active, nonacademic activities should be scheduled.

Novelty

Presentation of novel, interesting, highly motivating material will improve attention. For example, increasing the novelty and interest level of tasks through use of increased stimulation (e.g., color, shape, texture) reduces activity level, enhances attention and

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self control, it is critical to make sure that the other (and perhaps more serious) problems are not left to smolder.

Given the variety of disorders that can be mistaken for ADD, or that may co-exist with ADD, a comprehensive evaluation of the child is always important. Numerous problems must be contemplated, assessed and "ruled out" before a diagnosis of ADD can be made. It is no longer sufficient to start treatment for ADD based on observations of "tuning out" or misbehavior. This disorder needs a psychomedical evaluation that matches our growing awareness of the complexity that goes by the simple name of ADD. ♦

Resources

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improves overall performance.

Structure and organization

Lessons should be carefully structured and important points clearly identified. For example, providing a lecture outline is a helpful note-taking aid that increases memory of main ideas. Students with ADHD perform better on memory tasks when material is meaningfully structured for them.

Rule reminders and visual cues

The rules given to students with ADHD must be well defined, specific and frequently reinforced through visible modes of presentation. Well-defined rules with clear consequences are essential. Relying on the student's memory of rules is not sufficient. Visual rule reminders or cues should be placed throughout the classroom. It is also helpful if rules are reviewed before activity transitions and following school breaks. For example, token economy systems are especially effective when the rules for these programs are reviewed daily.

Auditory cues

Providing students with ADHD auditory cues that prompt appropriate classroom behavior is helpful. For example, use of a tape with tones placed at irregular intervals to remind students to monitor their on-task behavior has been found to improve arithmetic productivity.

Pacing of work

When possible, it is helpful to allow students with ADHD to set their own pace for task completion. The intensity of problematic ADHD behaviors is less when work is self paced, as compared to situations where work is paced by others.

Instructions

Because students with ADHD have difficulty following multi-step directions, it is important for instruction to be short, specific and direct. Further, to ensure understanding, it is helpful if these students are asked to rephrase directions in their own words. Additionally, teachers must be prepared to repeat directions frequently, and recognize that students often may not have paid attention to what was said.

Productive physical movement

The student with ADHD may have difficulty sitting still. Thus, productive physical movement should be planned. It is appropriate to allow the student with ADHD opportunities for controlled movement and to develop a repertoire of physical activities for the entire class such as stretch breaks. Other examples might include a trip to the office, a chance to sharpen a pencil, taking a note to another teacher, watering the plants, feeding classroom pets, or simply standing at a desk while completing classwork. Alternating seat work activities with other activities that allow for movement is essential. It is also important to keep in mind that on some days it will be more difficult for the student to sit still than on others. Thus, teachers need to be flexible and modify instructional demands accordingly.

Active vs. passive involvement

In line with the idea of providing for productive physical movement, tasks that require active (as opposed to passive) responses may help hyperactive students channel their disruptive behaviors into constructive responses. While it may be problematic for these children to sit and listen to a long lecture, teachers might find that students with ADHD can be successful participants in the same lecture when asked to help (e.g., help with audio-visual aids, write important points on the chalk board, etc.).

Distractions

Generally, research has not supported the effectiveness of complete elimination of all irrelevant stimuli from the student's environment. However, as these students have difficulty paying attention to begin with, it is important that attractive alternatives to the task at hand be minimized. For example, activity centers, mobiles, aquariums and terrariums should not be placed within the student's visual field.

Anticipation

Knowledge of ADHD and its primary symptoms is helpful in anticipating difficult situations. It is important to keep in mind that some situations will be more difficult for than others. For example, effortful problem solving tasks are especially problematic. These situations should be anticipated and appropriate accommodations made. When presenting a task that the teacher suspects might exceed the student's attentional capacity, it is appropriate to reduce assignment length and emphasize quality as opposed to quantity.

Contingency Management: Encouraging Appropriate Behavior

Although classroom environment changes can be helpful in reducing problematic behaviors and learning difficulties, by themselves they are typically not sufficient. Thus, contingencies need to be available that reinforce appropriate or desired behaviors, and discourage inappropriate or undesired behaviors.

Powerful external reinforcement

First, it is important to keep in mind that the contingencies or consequences used with these students must be delivered more immediately and frequently than is typically the case. Additionally, the consequences used need to be more powerful and of a higher magnitude than is required for students without ADHD. Students with ADHD need external criteria for success and need a pay-off for increased performance. Relying on intangible rewards is not enough.

Use of *both* negative and positive consequences are essential when working with ADHD students. However, before negative consequences can be implemented, appropriate and rich incentives should first be developed to reinforce desired behavior. It is important to give much encouragement, praise and affection as these students are easily discouraged. When negative consequences are administered, they should be given in a fashion that does not embarrass or put down students. Also, it is important to keep in mind that the rewards used with these students lose their reinforcing power quickly and must be changed or rotated frequently.

Token economy systems

These systems are an example of a behavioral strategy proven to be helpful in improving both the academic and behavioral functioning of students with ADHD. These systems typically involved

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giving students tokens (e.g., poker chips) when they display appropriate behavior. These tokens are in turn exchanged for tangible rewards or privileges at specified times.

Response-cost programs

While verbal reprimands are sufficient for some students, more powerful negative consequences, such as response-cost programs, are needed for others. These programs provide mild punishment when problem behavior is displayed. For example, a student may lose earned points or privileges when previously specified rules are broken. There is evidence that such programming decreases ADHD symptoms such as impulsivity. A specific response-cost program found to be effective with ADHD students involves giving a specific number of points at the start of each day. When a rule is broken (a problem behavior is displayed), points are taken away. Thus, to maintain their points students must avoid breaking the rule. At the end of the period or day, students are typically allowed to exchange the points they have earned for a tangible reward or privilege.

Time-out

Removing the student from positive reinforcement, or time-out, typically involves removing the student from classroom activities. Time-out can be effective in reducing aggressive and disruptive actions in the classroom, especially when these behaviors are strengthened by peer attention. They are not helpful, however, when problem behavior is a result of the students desire to avoid school work. The time-out area should be a pleasant environment and a student should be placed in it for only a short time. Time-out is ended based upon the student's attitude. At its conclusion a discussion of what went wrong and how to prevent the problem in the future takes place. While these procedures are effective with ADHD students, it is recommend that they be used only with the most disruptive classroom behaviors and only when there is a trained staff.

Summary

As students with ADHD are a heterogeneous group, there is no one intervention (or set of interventions) that will improve the classroom functioning of all of these students. Thus, it is suggested that classroom modifications be tailored to the unique needs of each student. In developing these modifications it is perhaps best to begin by examining how the classroom environment might be changed to set up the student with ADHD for success. The next step is to consider the implementation of a contingency management system designed to provide external incentives for appropriate classroom behaviors. In doing so it is important to remember that behavior management programs must be consistently applied. Further, it is essential to avoid excessive use of negative consequences (such as reprimands, time-out). In all cost programs, it is important to avoid the use of unrealistic standards that result in excessive point or privilege loss. Students must experience success. In other words, it is essential that students be frequently reinforced for what we want them to do, rather than simply punished for what we do not want them to do. ♦

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Book Review

ADHD Handbook for Families: A Guide to Communicating with Professionals

By Paul Weingartner (Child & Family Press, 1999; ISBN 0878687505)

Reviewed by Donna M. Burgess, NCSP

This book is a nice introduction to ADHD for individuals, parents or families that are dealing with the disorder for the first time. Throughout the book, concepts are explained using several real-life examples that make them easier to comprehend. Weingartner's perspective is unique in that he is diagnosed with ADHD himself, and he often draws from his own experiences to help readers understand what it is like to struggle with hyperactivity and inattentive behaviors. Given that the author is speaking as both a person who has learned to be successful living with ADHD, as well as a professional who helps others deal with the disorder, readers have the sense that they are gaining honest, "insider" information.

Weingartner begins by describing what it feels like to have ADHD. He accomplishes this by having readers imagine themselves in different situations where they are struggling with distractions and becoming increasingly confused and frustrated. He details the various reactions that a person with ADHD elicits from the people he or she interacts with. Weingartner emphasizes the fact the ADHD is a neurobiological disorder that has inconsistent symptoms, can be difficult to diagnose, and is likely to remain evident throughout one's lifetime. Behavioral expectations can differ depending on the environment; therefore, these symptoms may not be evident in every situation.

The next few chapters describe the process of diagnosing ADHD. The author identifies the various individuals who would be part of a comprehensive assessment and the type of data each person would collect. He then offers tips for parents on how best to document the behaviors they observe. A sample form is provided that parents can use to communicate effectively with other professionals. Case examples are presented using these sample forms. Weingartner stresses that parent information is invaluable and he provides support in these chapters for parents to participate confidently in the evaluation process.

The author then discusses medical and psychosocial interventions, as these methods have the most research support endorsing their effectiveness. Parents are encouraged to consider using both interventions as best practice. Common fears about medication and its side effects are discussed, as well as the variety of medications that are used today to treat ADHD. The author stresses that individuals will have unique, individual reactions to medical treatment. In the chapter on psychosocial interventions, the author explains the theory and effective practice of behavior modification. He includes excellent examples of how behavior modification is a natural part of all our lives. The importance of selecting appropriate, immediate and consistent consequences for behavior is discussed. Weingartner also highlights several ways parents can ensure their behavior modification program will be successful, such as catching their child "being good," identifying irritating behaviors that can be ignored, and giving their child some input into the program itself.

Behavior modification is addressed more specifically in the next few chapters. Weingartner guides readers through a step-by-step process to set up a behavior contract. Parents are encouraged to commit to a plan, even if unwanted behaviors escalate at first, as an increase in undesirable behavior is a common occurrence. He then reminds readers that data collection does not end once ADHD is diagnosed but, instead, should be continued to help monitor target behaviors and evaluate the effectiveness of interventions. Two sample behavior contracts are also presented that address common complaints regarding the behavior of students with ADHD. Weingartner also dedicates an entire chapter to various strategies that can be used to gain immediate results in working with a child with ADHD. While they can be part of a comprehensive behavior modification plan, these strategies can also be applied individually, allowing parents to gain some control while they work on developing a plan of action.

Weingartner finishes the book with a detailed account of his own experience with ADHD. He leads readers through every step outlined in his chapters and how he applied each one to his own situation. His story helps assure parents that they are capable of being active, informed participants in the process of diagnosing and treating ADHD. Weingartner summarizes common myths about ADHD and reminds readers that their primary goal is to understand the feelings and experiences of children with ADHD, show their children that they care, and work towards helping them realize their full potential. ♦

Donna M. Burgess, NCSP, is the school psychologist at the Dutile Elementary School in Billerica, Massachusetts. This review originally appeared in the library of the Global School Psychology Network at <www.dac.neu.edu/cp/consult> and is reprinted with permission. This article is reprinted from NASP Communiqué, March 2000.

Innovative Practice

ADD Resource Boxes

by Scott Poland, NCSP

The Cypress-Fairbanks Independent School District in Houston, TX recognized a need for school personnel and parents to have more information on Attention Deficit Disorder. With grant funding obtained from the Texas Education Agency, a district-wide resource project was initiated: For each of the 50 district schools, a "resource box" was created, containing videotapes, pamphlets, articles and books on ADD. In addition, each school receives the CHADD newsletter each month. These materials are available for loan to teachers and parents. These resources boxes have been very popular and many students have benefited form the information that is available. ♦

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Attention Problems
Strategies for Parents

by Marcia Weill

Hyperactivity: Provide External Structure

Physical Controls

- Include regular exercise, balanced diet, adequate sleep, medication if appropriate
- Check schedules: mornings usually best for learning, need calm routine at bedtime
- Check environment for safety and remove treasured items, prevent problems

Predictability

- Use consistent rules across time and place
- Prepare for changes to new activity
- Practice simple daily routines
- Have regular contact with school

Distractibility: Focus on Priorities

Priorities

- Organize backpack and notebook
- Have a "Launch Pad" area for next morning's materials and messages
- Encourage on-task behavior
- Request special education assessment if appropriate

Directions

- Use simple, positive directions showing what to do instead of what not to do
- Give visual clues

Distractors

- Provide regular time and clean area for doing homework
- Limit and balance extra curricular activities

Impulsivity: Build Self-Confidence

Social Skills

- Build on strengths
- Teach game-playing skills, taking turns and making choices
- Encourage noncompetitive sports (karate, gymnastics, swimming)
- Teach friendship skills (making requests, giving compliments, less rough play)

Parent Support

- Enroll in classes in behavior management
- Join support groups
- Use "special time" for bonding

Counseling and Management

- Use strategies to reduce impulsive behavior
- Model positive self-talk and goal-setting
- Reward frequently ♦

Marcia Weill is a school psychologist in the Folsum-Cordova (CA) school district. Adapted from material previously published by the California Association of School Psychologists in CASP Today, *August, 1994. Reprinted from* Helping Children at Home and School: Handouts from your School Psychologist *(© NASP, 1998).*

ADHD in Cyberspace

CHADD:
<*http://www.chadd.org*>

National Association for ADHD:
<*http://www.attentiondisorder.com/*>

ADD/ADHD Information Library:
<*http://www.newideas.net/p0000374.htm* >

Attention Deficit Disorder Archive:
<*http://www.realtime.net/~cyanosis/add*>

Council for Exceptional Children:
<*http://www.cec.sped.org*>

Federal Resource Center for Special Education:
<*http://dssc.org/frc*>

Pediatric Development and Behavior:
<*http://www.dbpeds.org*>

National Institute of Child Health and Human Development:
<*http://nih.nichd.gov*>

National Information Center for Children & Youth with Disabilities (NICHCY):
<*http://www.nichcy.org*> ♦

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